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Navigating stigma, survival, and sex in contexts of social inequity among young transgender women and sexually diverse men in Kingston, Jamaica

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Abstract: *Social inequities, including stigma, criminalisation of same-sex practices, and poverty, elevate HIV exposure among young transgender women and sexually diverse men in Jamaica. Yet the ways transgender women and sexually diverse men in Jamaica navigate sex and HIV in contexts of social inequity are underexplored. The study objective was to explore experiences and perceptions of sexual decision-making and HIV risk among young (aged 18–30) sexually diverse men and transgender women in Kingston, Jamaica. We conducted a community-based qualitative study in Kingston that involved in-depth individual interviews (transgender women:* n = *20; sexually diverse men:* n = *20), 2 focus groups (transgender women:* n = *8; sexually diverse men:* n = *10) and 13 key informant interviews. Focus groups and interviews were digitally recorded, transcribed verbatim, and analysed with a thematic approach. Findings suggest that transgender women and sexually diverse men in Kingston are aware of, and managing survival challenges and HIV risks in contexts of social inequity. Daily survival challenges include stigma and a lack of human rights protections that contributed to barriers to employment, housing, healthcare, education, and exposure to violence. Challenges maintaining sexual relationships included the need to hide for safety, often resulting in difficulties forming lasting relationships. These survival and relationship challenges converged to lower self-esteem and self-acceptance. In the face of these challenges, participants navigated sexual risk and pleasure. Findings provide insight into agency and sexual decision-making processes in contexts of social inequities. Findings can inform multi-level strategies to promote social equity, sexual health, and HIV prevention with young transgender women and sexually diverse men in Jamaica.* DOI: 10.1080/09688080.2018.1538760

Keywords: transgender women, gay men, stigma, sexual rights, sexual health, Jamaica

Introduction

Across the globe, sexually and gender diverse persons experience health inequities, including over-representation in HIV infections.[1,2] This is also true in Caribbean contexts[3,4] such as Jamaica, where HIV prevalence is estimated at 25.2%[5] among transgender (trans) women, and between 13.5%[6] and 32.8%[7,8] among gay and bisexual men. These numbers are far greater than Jamaica's general population HIV prevalence of 1.7%.[9] Contexts of social inequity and limited human rights constrain sexual rights and, in turn, produce sexual health inequities among lesbian, gay, bisexual and transgender (LGBT) persons.[10]

Sexual orientation refers to enduring physical, romantic and/or emotional attraction; gay and lesbian refer to when these attractions are toward persons of the same gender, and bisexual to

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those with physical, romantic and/or emotional attractions to the same or different gender.[11] The term "men who have sex with men" (MSM) was developed to focus on sexual practices, rather than identities, to include men who do not identify as gay or bisexual in HIV prevention.[12] Gender identity refers to the innermost concept of one's own gender and sense of self[11]; transgender is an overarching term to encompass persons whose felt gender identity does not correspond with the societal expectations regarding the sex they were assigned at birth.[13] Gender expression refers to how persons express their gender identity, including clothing, behaviour and other appearance markers (e.g. hairstyle). Gender expression may align with, or contradict, social expectations of masculinity and femininity.[11] Sexual orientation and gender identity should not be conflated, as trans persons have various sexual orientations and gay and bisexual persons have different gender expressions.[12] We use the terms sexually and gender diverse to refer to the multiple ways that persons claim non-heterosexual, non-cisgender identities and affiliations across different contexts and interactions.

Social inequities towards LGBT persons are exacerbated by Jamaica's legal context where there is no human rights protection from anti-LGBT discrimination. Additionally, anal sex between men (targeted by the "buggery" law) is criminalised in the Offences Against the Person Act of 1864 introduced under British colonisation.[10] Negative attitudes and bias toward LGBT persons are rooted in inequitable gender norms in Jamaica.[14] Discrimination against LGBT persons has been situated within Jamaican culture's larger social norms regarding sexual restrictiveness.[15] To illustrate, West reported similar negative attitudes among Jamaicans toward anal sex between men and anal sex between men and women, suggesting that anti-LGBT prejudice may be part of larger social norms regulating gender-conforming sexual practices.[15] It is within this backdrop of social inequities reinforced by criminalisation, a lack of human rights protection, and rigid gender norms that LGBT persons navigate survival and sexual lives.

Social inequities may elevate HIV exposure by constraining access to HIV prevention information, preventive resources such as condoms and lubricant, HIV and other sexually transmitted infections (STI) testing, care and treatment access.[16–18] Recent quantitative studies in Jamaica reported that among trans women, social (homelessness, stigma) and health (depression, STI history) inequities were associated with HIV infection.[5] Among gay and bisexual men in Jamaica, HIV infection has also been associated with social (physical abuse, poverty, homelessness, stigma) and health (STI history) inequities.[6] In Jamaica, 44% of trans women, and 22% of gay and bisexual men reported experiencing police harassment.[19] Police harassment was higher among more marginalised participants (those living with HIV, food insecure, and reporting HIV-related and transgender stigma), suggesting that persons who experience social and health inequities may be at elevated risk for police harassment.[19]

Stigmatising attitudes toward LGBT persons have been reported among healthcare and social providers in Jamaica.[20–24] Qualitative research with transgender women and sexually diverse men in Jamaica reported HIV testing barriers including mistreatment by healthcare providers, confidentiality breaches, and HIV-related stigma; facilitators included HIV knowledge, social support, and accessible testing services.[25] Less research is available on how trans women and sexually diverse men in Jamaica perceive and navigate daily survival, sex and HIV risks in contexts of social inequity.

The syndemics theoretical framework provides a valuable approach to explore how social inequities such as poverty, homo/transphobia and other processes of marginalisation contribute to health inequities.[26–30] Singer et al[31] described the "biosocial complex" as the interaction and co-occurrence of health issues within larger social environmental contexts. Syndemics analyses explore how multiple social and health inequities may be experienced concurrently. For instance, syndemics among gay and bisexual men include experiences of depression, isolation and loneliness, low self-esteem,[32] internalised homophobia,[33] and low social support.[34] Adam et al[35] describe the ways HIV risk management strategies are employed by gay and bisexual men who experience syndemics. Among trans women in the US, a syndemic of co-occurring psychosocial factors (low self-esteem, substance use, violence) and social marginalisation (sex work, homelessness, incarceration) was associated with sexual risk practices and HIV infection.[36] Sociocultural, political, economic and historical

inequities increase the likelihood of experiencing syndemics.[37]

There is insufficient research exploring syndemics, and the ways in which social and health inequities are navigated, in contexts where LGBT persons experience limited human rights protection. The syndemics framework may be particularly relevant for understanding how trans women and sexually diverse men in Jamaica perceive their sexual health and HIV vulnerabilities, as well as how they negotiate these perceived risks. Yet resilience and the concept of agency, how persons enact strategies to survive, resist and shift power relations,[38] is understudied in contexts of syndemics. The larger research aim of this paper is to expand knowledge of how to advance health, wellbeing and equity with trans women and sexually diverse men in Jamaica. Specifically, the study objective was to explore the experiences and perceptions of sexual decision-making and HIV risk among young trans women and sexually diverse men in Jamaica.

Methods

Participant recruitment and data collection

We conducted a qualitative study with a community-based AIDS service organisation that provides HIV prevention and care services, advocacy, and programs for LGBT persons as well as people living with HIV, sex workers and other groups affected by HIV in Jamaica. This study focused on young trans women and sexually diverse men living in Kingston, Jamaica. These young populations were selected as they are both overrepresented in Jamaica's and the larger global HIV epidemics. They may also experience social and familial exclusion, and have limited financial and educational resources. These young people have unique HIV prevention needs and preferences but are often overlooked in HIV research.[39]

Peer researchers ($N = 6$) who identified as LGBT were hired and trained to conduct focus groups and in-depth individual interviews with young trans women and sexually diverse men. We first conducted 2 focus groups (trans women: $n = 8$; sexually diverse men: $n = 10$) to explore the social and structural contexts of inequity and HIV perceptions and prevention priorities. We then conducted in-depth individual interviews (trans women: $n = 20$; sexually diverse men: $n = 20$) to further explore the social and structural contexts of sexual health and HIV. We also conducted 13 in-depth interviews with key informants, who included persons working at LGBT agencies, outreach workers, advocates and HIV clinicians and program workers. Community partners identified peer researchers who, in addition to helping with data collection, also helped with participant recruitment and pilot testing the interview and focus group guide. Peer research assistants conducted purposive sampling[40] from community agencies focused on HIV and LGBT services and rights, and word-of-mouth, to recruit trans women and sexually diverse men living in Kingston and surrounding areas.

Written informed consent was obtained from each participant prior to the beginning of the study, whereby the peer researcher read aloud the consent form and answered any questions. The individual interviews and focus groups were conducted in a semi-structured format, guided by open-ended questions, which were developed in partnership with community collaborators. Interview and focus group questions focused on: lived experiences as a young trans woman or sexually diverse man in Jamaica; HIV risk perceptions; engagement in HIV prevention and care; and strategies employed to mitigate HIV risk.

Participants received a $15 USD honorarium for their time and transportation costs. This study was developed and implemented in collaboration with several local, community-based agencies centered on HIV prevention, as well as LGBT health and human rights organisations. Research Ethics Board approval for this study was secured from the University of Toronto (reference # 29359) and the University of the West Indies, Mona Campus.

The study population included persons aged 18–30 years old; living in Kingston, Jamaica; who self-identified as a gay, bisexual, same-sex attracted man, and/or a man who has sex with men (MSM), or as a trans woman. Individuals who met the inclusion criteria were invited to participate in a 45 min one-on-one interview and/or a 90-minute focus group held at a community-based agency in Kingston.

Data analysis

Focus groups and interviews were digitally recorded and transcribed verbatim and analysed using NVivo 10 data analysis software.[41] We employed a thematic approach to data analysis;

this theoretically flexible approach involves both inductive and deductive analysis to identify patterns that emerge in the data. Multiple team members read the entire data set in a recursive manner, going back and forth as needed for clarity and further understanding, and taking notes of relevant ideas related to HIV and sexual health.[42] We then generated initial codes that emerged across the data set, and collated these codes into initial themes, further developing a thematic map and refining the themes.[42,43] We conducted member checking with the research investigators, coordinator and peer researchers to increase the validity of findings.

Results

The mean age of trans women interview participants ($n = 20$) was 23.3 years (SD: 3.79) and for gay/bisexual men ($n = 20$) was 22.25 (SD: 1.77). Trans women interview participants identified as gay (65%) followed by heterosexual (35%). Trans women focus group participants identified as gay (50%) and heterosexual (50%). Male interview participants identified as gay (60%), bisexual (30%), MSM (10%), and pansexual (10%). Male focus group participants identified as gay (80%) and pansexual (20%). Pansexual refers to persons with sexual, romantic and emotional attractions that are not limited to a person's gender identity or sexual orientation.[44]

Findings suggest that trans women and sexually diverse men in Jamaica experience survival challenges that increase HIV vulnerabilities. In the face of these challenges, participants discussed strategies by which they navigated sexual risk and pleasure.

Survival challenges

Survival challenges were discussed with regards to employment, housing, health care access, education, socio-economic class, and violence. These factors converged to contribute to increased HIV vulnerabilities among trans women and sexually diverse men.

Participants described a discriminatory social climate where "employment is an issue" (bisexual man, participant #120), explaining that it is "because of your sexual orientation, [that] you can't get a job" (bisexual man, participant #116). This may also be exacerbated by young age – a gay man articulated that it was particularly difficult to acquire employment as a young person: "As a LGBT youth, it adds another level of disadvantage as discrimination comes" (participant #118).

Several participants indicated that they engaged in transactional sex to survive as a result of societal stigma that limited employment opportunities. For example, a trans woman (participant #217) described that she perceived trans women to be at elevated risk for HIV due to survival transactional sex. A key informant echoed this observation:

"There is no employment whatsoever and the only way you can see your way through is by self-employment. For the most part, people in the transgender community are not educated enough to be self-employed. If they go to one of the training institutions, they will get turned away. So, they don't have that avenue to get trained to be self-sufficient. So, they do the one thing that they don't need training for and that's sex work."

Numerous participants suggested that the higher HIV prevalence within their communities is a consequence of their social environment. This also makes it difficult for trans women and sexually diverse men to secure traditional employment. Another key survival challenge was acquiring housing. Participants reported that anti-LGBT sentiment is embedded in housing laws, resulting in people perceived to be LGBT experiencing difficulties accessing and maintaining housing. A key informant described their experience in attempting to help a gay male client rent an apartment:

"I was with a gay person the other day looking for housing and I was actually nervous on their behalf because someone can actually report them, depending on where they live and the landlord. Now, I am thinking that for this person to look for somewhere to live, it is not an easy process. There are factors to consider such as the landlord and because it is illegal for them to have such a relationship."

Homelessness and constant fear of eviction were discussed by participants as not solely the result of housing laws, but also due to family exclusion resulting in young people being forced to leave home. Participants connected homelessness and eviction issues with an increase in HIV risk among LGBT youth. For example, a bisexual man described that "the more flamboyant a person is, the more likely that person is to be kicked out. When you are young and kicked out, you will

have to have sex with persons to make ends meet" (participant #120). This suggests the importance of considering how gender non-conforming expression and identity may increase social inequities toward LGBT persons.

Discrimination experiences were also reported by healthcare providers based on participants' actual or perceived sexual orientation and/or gender identity. For example, a gay man (participant #111) articulated that he and his peers were often deterred from seeking healthcare services due to discriminatory healthcare providers:

"They tend to look at you as being one of the worst, so that doesn't allow you to feel welcome and those are some of the things that shun you away. So they shun you away now so you don't want to go there for any information to get tested, you know for any condom or lube."

The above quote highlights how this healthcare mistreatment reduces engagement in HIV testing and access to prevention tools. Numerous participants reported verbal abuse, feeling judged, discrimination, and physical violence as risks they must take to receive medical testing or treatment. A trans woman focus group participant described how healthcare stigma was exacerbated for trans persons who were homeless:

"For healthcare remember they are homeless people, they can't facilitate private health care so for them to go to public health care it is a big challenge with the fear of discrimination, thinking they are going to be attacked, physical abuse; verbal abuse; so the health care is the biggest thing."

Another gay man explained how feelings of shame and disapproval prevent people from accessing safer-sex resources such as lubricants, despite education efforts:

"People are trying their best on how to educate others on practicing safe sex. But, with the continuous disapproval and shame, persons do tend to hide and do certain things. No man that I know will go into a pharmacy and say that they are going to buy lube. That gives you a level of shame. It shouldn't, but it does." (participant #117)

Healthcare discrimination also prevented barriers to accessing condoms: "I am at risk because of my sexuality. If I go to the clinic for help, they will look down on me. They will ask why I am coming there for condoms. I am not a heterosexual person so I am discriminated against by all categories of society." (trans woman participant #220). Participants suggested that health care discrimination increases HIV risk among sexually diverse men and trans women. A gay man stated that "if the general public was to be tolerant or persons would just do their jobs as health care professionals from that perspective that would help to reduce the risk of the spreading of the HIV virus and other STIs" (participant #102).

Some participants described inadequate sexual health education as a significant risk factor for HIV acquisition. A gay man explained that: "in Jamaica you actually have no comprehensive sexual education, nothing that teaches young people how to properly exercise responsibility when you're having sex" (participant #114). This was reinforced by a key informant who described that "there is a lack of knowledge. I think that's the biggest thing that increases the risk of HIV". Another gay man discussed the need for sex education and decriminalisation of same-sex practices: "education and the lifting of the buggery law [would decrease HIV prevalence]. If there was more tolerance for it, I don't think it would be so widespread. Because people would be more comfortable with gay guys" (participant #109). The need for education also applied to community education for stigma reduction. In response to the question "what would help your community be more accepting of transgender women" a transgender woman (participant #220) suggested: "Education. Being more informed. The ignorance that people have will not help the situation. They need to be educated."

Socio-economic status shaped experiences of stigma and access to LGBT communities. Key informants theorised that social class shapes the experiences of LGBT persons in Jamaica, and as a result "people experience discrimination differently based on class". A sexually diverse man in the focus group, in response to another participant who wondered why some persons could form long-term relationships while others could not responded by saying: "I think it is class, age, money and geography. Class and money (and education) provide you with a whole lot of buffers. When you are poor, you are a 'batty man' [negative term for gay men], but when you have money you are a homosexual. It is two different things." Another key informant echoed the observation, noting that LGBT youth who have money are able

to openly express their sexual identity, and go to clubs and parties, whereas poorer LGBT youth are "not so privileged … generally, the social class determines who comes out and who doesn't."

Violence compromised survival and wellbeing. Participants described experiencing and fearing violence. One gay man (participant #114) puzzled over the insult "fish", discussing that "fish is the one I don't understand the most because it suggests that you are inhuman and you don't deserve to exist." The dehumanisation of trans women and sexually diverse men was a common theme. Specifically, participants state that they are treated as though they are "not a human" (gay man, participant #111), "like animals" (trans participant #212), and as a "piece of trash" (trans participant #215). A trans woman explained that: "When there is stigma and discrimination, the pain is unreal because you suffer the scars emotionally" (participant #217).

Death threats and feeling physically endangered and unsafe were common experiences for participants. For example, a bisexual man (participant #115) expressed that " … most of us fear for our lives" and a pansexual man reported that society says "you must die" (#110). Trans women described pervasive violence: "Common experiences that transgender women face in Jamaica are bashing, whether physically or verbally" (#212). Other trans women participants reported experiences of physical violence: "Persons are … beaten for what they do or who they really are" (#217) and "guys would gang up to beat me" (#219). Participants also discussed the harmful impacts of this violence: "Ok, yea it's disgusting because sometimes you not even see them, yah walk with your head straight and them jump up 'batty boy yuh fi dead' [gay person you are going to die] and them stone you and whatever, as I said I feel ripped apart and I feel hurt" (trans participant #212).

To navigate these survival challenges and reduce exposure to stigma, discrimination and violence, participants described selectively choosing to hide their identities to stay safe. A trans woman (#220) described the advice she would give to other trans women: "they have to do what they have to do to survive. It means being ourselves but dressing up like a boy when needed as a way of survival." When a trans woman was asked if "they feel a need to hide [their] gender identity from the larger society", she responded that:

"If it's for [her] own safety, then why not? What beats your safety? You want to live as transgender but if you die, you just die. If you want to live as a transgender woman, that is fine. If you are not in the place to expose your lifestyle or image, then don't." (participant #217)

A gay man contextualised the inability of LGBT persons to be themselves within the lack of human rights protection in Jamaica:

"Apart from being discriminated against and stigmatized, our rights are being infringed on daily. We are not able to fully be ourselves because this might put us in danger. We are not given hope to say that we are a part of society, we are not given the human right to say who we are." (participant #117)

The need to conceal one's sexual and/or gender identity was discussed as contextual, where persons in the inner city might have worse outcomes than those in suburban areas, once again suggesting the importance of considering class and geography. A gay man discussed the importance of persons being able to "understand [their] situation" to navigate safety:

"Not everything that works for another person will work for you. Yes, we all want to be brave and be who we are, but we also have to be practical. You have to assess your situation and know what's happening. For example, a person in an inner-city area will face more repercussions considering that these people are more violent, and as such, is more likely to get injured. Being bold in a university is good, as more people are free thinking and open minded. This is not the case in high school where people are more close-minded and stuck in a general point of view. You have to understand the risks you are taking depending on where you are, and then move from there." (participant #118)

Most participants reported difficulty forming monogamous long-term relationships, as well as maintaining positive relationships with themselves due to the need to conceal their self-identity. Numerous participants described that the need to hide their identities often resulted in short-term, casual and/or anonymous relationships. A key informant explained:

"A lot of gay men are not willing to take that risk because they are afraid. If I meet a guy and fall in love with this guy, the next step will be living

together, but where will we live? We can't live in my community because they will kill us. I can't afford to rent somewhere where it is safe for us, so, we will have to have a visiting relationship. So, it can be hard for gay men to form commitments, more so, long term commitments. They don't know that it is possible because they don't see it."

These relationship challenges were often a deterrent: "people think that it is too restrictive so why bother be in a relationship" (gay man, participant #118). The need to conceal sexual and/or gender identity as a survival risk management strategy was described as contextual, and as a constraint to realise one's potential and engage in sexual relationships.

Navigating sexual risk and pleasure

Despite the aforementioned challenges, participant narratives suggest that many trans women and sexually diverse men consciously engaged in risk management strategies to navigate sexual and survival risks. Most participants discussed the importance of using condoms and taking precautions to reduce HIV exposure, some describing that they "always use a condom" (trans woman participant #212). Participants discussed solutions to balancing sexual risk and discrimination, such as purchasing lubricant online

"Me personally would not purchase lube, if I'm going to the store to purchase condom with the lube then what people might say; you know 'why me buy lube?' and all these things. I buy lube online from the United States to come out here, that's how bad it is." (gay man, participant #113)

Many participants believed that having sex with multiple partners elevates HIV risk, and discussed maintaining monogamous sexual relationships or limiting their number of sexual partners as a way to mitigate HIV risk. For example, a bisexual man reported not using condoms, but only having sex with one partner: "I fuck and I don't use a condom. I know it sounds bad, but when I fuck, I fuck one person alone. It mitigates the risk to an extent" (participant #120). Another bisexual man described getting HIV and STI tests with their partners before starting a sexual relationship:

"I think I have a low risk because I am a very picky person. I don't sleep with any and everybody. I have to trust you enough to do these nice little things that we are to do as a couple. And believe me, we are going to get tested before anything will happen." (participant #116)

Participants detailed the role of pleasure and desire in sexual decision-making processes. For example, during a focus group, a trans woman described that

"I would say it is a lie to say you go with every client with a condom because if I am on the road and I see a boy, whether he is gay or not, and in the sense that he is pretty or a boy that we like who is cute and bowleg and has tattoos and flashy … "

and in response, a participant stated: "Oh God we wouldn't remember anything about using condoms, we are like hmmm yeah." Some participants suggest that people prefer sex without condoms more: "so it's not hard for me most a them it's hard for them cause them like the raw sex and them want feel everything" (trans participant #212). Another trans woman described the tension between pleasure and safety: "I love it raw, I love to feel the sweetness and everything. When you put on the condom it's like you are using a fake dildo. I want to feel the raw meat and everything. But using the condom is the safer way" (participant #219). This tension between desire and safety was also discussed in relation to HIV:

"The urge. If you have a strong urge and you see someone that you are interested in, you will want to have sex. You may not use protection. In some cases you have protection but because of our interest, we say, 'Fuck the condom,' and just go ahead bare. This contributes to the higher number of persons being infected." (gay man, participant #119)

Navigating self-acceptance and support

Participants were asked what advice they would give another LGBT person in Jamaica, and overwhelmingly the responses were associated with finding self-love and respect in the face of discrimination. For example, participants expressed that "it all boils down to love of self" (bisexual man, participant #116) and others gave the advice to "be who you are and live for yourself" (trans participant #212), and "have self-confidence and believe in themselves" (trans participant #202).

Some participants recommended strategies to maintain a positive attitude and personal wellness, including: "prayer and meditation" (bisexual man, participant #116), "watching positive YouTube

videos" (gay man, participant #120), and trying to "do positive stuff, again go after your goal" (gay man, participant #113). Many participants discussed the need to ignore unaccepting persons in order to realise self-acceptance, and to "block people out of your mind" (trans participant #218).

In addition to focusing on building one's individual coping skills, participants highlighted the importance of finding and accessing social support. Many suggested trying to "find a group to confide in" (pansexual man, participant #106) and stressed the importance of "having a support system or at least have person to help you figure things out" (bisexual man, participant #108). Participants highlighted the importance of having someone to talk to that they can trust, especially to fight feelings of being alone (gay man, participant #114). A trans woman specifically recommended going to safe spaces to find support: "try to find a more warm welcome space and go and stay and try to find some new friends" (participant #210).

When asked "how can you reduce this risk of HIV among LGBT youth", a bisexual man suggested:

"Empowerment … telling persons, having them believe that they are important, that they are just as contributory to society as everybody else. Giving them the faith to accept themselves and love themselves and they will make positive choices … Don't be silenced by our society." (participant #115)

These findings suggest that trans women and sexually diverse men are actively trying to maintain their personal health and wellbeing through efforts to improve their self-esteem and connections to others.

Discussion

Study findings reveal that young trans women and sexually diverse men in Kingston, Jamaica are actively aware of, and managing, life challenges and sexual decision-making in contexts of social inequity. These findings point to HIV vulnerabilities that are exacerbated by profound daily survival challenges, including barriers to employment, housing, healthcare access, education, and violence. These barriers often resulted in persons concealing their sexual and/or gender identities, in turn presenting barriers to engaging in long-term sexual relationships. Balancing sexual risk and sexual pleasure were discussed within this larger context of negotiating survival and social inequities. In the face of these challenges, participants discussed the importance of self-love and social support. The convergence of social inequities (evidenced by stigma, discrimination and violence) with health inequities (limited access to HIV/STI information and prevention tools) are indicative of a syndemic in urgent need of attention.

In line with syndemics research, participants discussed how HIV vulnerabilities were elevated for economically insecure and sex working persons. While participants did discuss knowing about safer sex, at times they enacted higher and lower risk management strategies depending on other competing demands and desires, in line with Adam et al's[35] discussion of the need to consider different sexual subjectivities in designing risk reduction programmes. Our findings reflect Singer et al's[30] conceptualisation of a "cultural logic of risk assessment" that argues that individuals that live within a syndemic make rational choices based on their socially inequitable environment. This approach posits that persons make rational decisions about sexual risk that might elevate HIV exposure while gaining logically calculated benefits.[30] In our study, participants weighed benefits (perceived sexual pleasure and freedom) and sexual risk (condomless sex) – the choice of these benefits is situated in a context where sexual (and human) rights are constrained and there are limited opportunities to experience sexual freedom and pleasure, thus could be perceived as rational. Participants also made rational decisions to reduce daily survival risks, such as concealing sexual and/or gender identities.

Prior research with this population that applied a social-ecological lens to understand HIV testing barriers and facilitators elucidated the need for targeted healthcare setting and provider interventions to reduce stigma and improve confidentiality.[25] The current analysis, informed by a syndemics framework, builds on these findings in several key ways. First, we demonstrate agency[38] in sexual decision-making processes, highlighting participants' awareness of ways in which they balance sexual risk and pleasure. Agency also encapsulates processes of persistence and survival,[38] demonstrated in participant narratives on decision-making regarding sexual and gender identity concealment and disclosure processes.

These relational forms of agency and knowledge, self-awareness, strengths and coping strategies among LGBT persons are less studied in contexts with limited human protection. Second, the current analysis extends beyond HIV testing to explore sexual practices at large and other survival concerns, shining a light on the social determinants of health.[18] Finally, these findings highlight the need for an intersectional approach[45] to contextualise social and health inequities, with particular attention to economically insecure and sex working young trans women and sexually diverse men.

Strategies to promote sexual health among young trans women and sexually diverse men can target larger social inequities that elevate HIV vulnerabilities, as well as interpersonal and intrapersonal vulnerabilities.[16,18] At the policy level, decriminalisation of same-sex sexual practices and LGBT human rights protection could have downstream effects on education, housing and healthcare access. LGBT non-discrimination policies in healthcare settings combined with healthcare provider stigma reduction training can increase healthcare engagement. Community programmes to provide alternative education and employment services and training for LGBT youth, such as offered by Jamaica AIDS Support for Life, can reduce economic vulnerabilities.[46] Community-level strategies could transform inequitable gender norms, lower violence, and reduce LGBT-stigma. At the interpersonal level, individual and group-based counselling can increase HIV/STI knowledge and safer-sex self-efficacy as well as improve self-esteem and increase social support.[16,18] Practitioners can be attentive to the strengths and agency of LGBT youth in the face of stigmatising social contexts.

Our study has limitations. First, it was conducted in one urban centre, and the experiences of trans women and sexually diverse men in Jamaica may be different outside of this setting. Second, we did not collect sufficient information to conduct analyses distinguishing the experiences between trans women and sexually diverse men. While the study included both trans women and sexually diverse men, we must be careful to not conflate the groups and to consider their differential experiences.[12] We note that trans women were more likely than sexually diverse men to discuss experiencing profound employment barriers that led to survival sex, and were more likely to report needing to conceal their gender identity for survival and violence prevention. Further research could explore how to develop culturally and gender-tailored prevention strategies for each of these populations. Gender non-conformity stigma,[47] and how it shapes the experiences of trans women and sexually diverse men, could be explored further. Additionally, we did not have a sufficient sample size to explore sexual orientation differences within our samples of trans women and sexually diverse men. Despite these limitations, our study is unique in exploring the occurrence of social and health inequities, informed by a syndemics lens, to contextualising sexual health among young trans women and sexually diverse men in Jamaica. It is also unique in exploring not only challenges but the ways people navigate survival and sexual decision-making.

Conclusions

In contexts of criminalisation and constrained human rights protection, young trans women and sexually diverse men in Jamaica experience social inequities that pose challenges to daily survival, and in turn, compromise sexual health and wellbeing. Even within contexts of social inequity, participants discussed ways in which they implemented agency to manage their sexual lives, sexual risks and sexual pleasure – at the same time managing survival risks through self-acceptance and social support. There is an urgent need for multi-level strategies to promote social equity, sexual health, and HIV prevention with young trans women and sexually diverse men in Jamaica.

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Résumé

Les inégalités sociales, notamment la stigmatisation, la pénalisation des pratiques entre personnes de même sexe et la pauvreté,

Resumen

Las inequidades sociales, que incluyen estigma, penalización de prácticas del mismo sexo y pobreza, elevan la exposición al VIH entre mujeres

augmentent l'exposition au VIH des jeunes femmes transsexuelles et hommes sexuellement différents à la Jamaïque. Pourtant, les façons dont les femmes transsexuelles et les hommes sexuellement différents gèrent les rapports sexuels et le VIH dans des contextes d'inégalité sociale font l'objet d'études trop rares. L'objectif de l'étude était d'analyser les expériences et les conceptions de la prise de décision sexuelle et du risque d'infection par le VIH chez les jeunes (âgés de 18 à 30 ans) hommes sexuellement différents et femmes transsexuelles à Kingston, Jamaïque. Nous avons réalisé une étude qualitative communautaire à Kingston avec des entretiens individuels approfondis (femmes transsexuelles : n = 8 ; hommes sexuellement différents : n = 10) et 13 entretiens avec des informateurs clés. Les discussions par groupe d'intérêt et les entretiens ont été enregistrés digitalement, transcris textuellement et analysés avec une approche thématique. Les résultats indiquent que les femmes transsexuelles et les hommes sexuellement différents à Kingston connaissaient et géraient les défis à la survie et les risques de VIH dans le contexte des inégalités sociales. Les difficultés quotidiennes pour la survie comprennent la stigmatisation et le manque de protection des droits de l'homme qui ont contribué à des obstacles à l'emploi, au logement, aux soins de santé, à l'éducation, et à l'exposition à la violence. Les embûches pour avoir des rapports sexuels, y compris la nécessité de se cacher par souci de sécurité, ont souvent abouti à des difficultés pour nouer des relations durables. Ces défis pour la survie et les relations ont convergé vers une faible estime et acceptation de soi. Face à ces écueils, les participants naviguaient entre risque sexuel et plaisir. Les conclusions donnent des pistes sur les processus de prise de décision sexuelle et d'action dans le contexte d'inégalités sociales. Elles peuvent guider des stratégies à plusieurs niveaux pour promouvoir l'égalité sociale, la santé sexuelle et la prévention du VIH auprès des jeunes femmes transsexuelles et hommes sexuellement différents à la Jamaïque.

transgénero jóvenes y hombres sexualmente diversos en Jamaica. Sin embargo, las maneras en que mujeres transgénero y hombres sexualmente diversos en Jamaica navegan las relaciones sexuales y el VIH en contextos de inequidad social están poco exploradas. El objetivo del estudio fue explorar experiencias y percepciones de la toma de decisiones sexuales y riesgo de VIH entre hombres jóvenes (de 18 a 30 años) sexualmente diversos y mujeres transgénero en Kingston, Jamaica. Realizamos un estudio cualitativo comunitario en Kingston que consistió en entrevistas individuales a profundidad (mujeres transgénero: n = 20; hombres sexualmente diversos: n = 20), 2 grupos focales (mujeres transgénero: n = 8; hombres sexualmente diversos: n = 10) y 13 entrevistas con informantes clave. Los grupos focales y las entrevistas fueron grabados digitalmente, transcritos textualmente y analizados con un enfoque temático. Los hallazgos indican que las mujeres transgénero y los hombres sexualmente diversos en Kingston son conscientes de, y manejan, los retos de supervivencia y riesgos de VIH en contextos de inequidad social. Ejemplos de retos diarios de supervivencia son: estigma y falta de protecciones de los derechos humanos que contribuyen a barreras para conseguir empleo, vivienda, servicios de salud y educación, así como exposición a violencia. Entre los retos de mantener relaciones sexuales figuran la necesidad de esconderse por su seguridad, lo cual a menudo causa dificultades para formar relaciones duraderas. Estos retos de supervivencia y relaciones convergieron para disminuir la autoestima y auto-aceptación. Ante estos retos, las personas participantes navegaron riesgo y placer sexual. Los hallazgos ofrecen mayor comprensión de la agencia y procesos de toma de decisiones sexuales en contextos de inequidades sociales, y pueden informar estrategias de múltiples niveles para promover la equidad social, salud sexual y prevención del VIH entre mujeres transgénero jóvenes y hombres sexualmente diversos en Jamaica.